Physician/Clinician Statement of Necessary Patient Care for a Household Member

PLEASE PRINT THE FANF INDIVIDUAL'S NAME, RECIPIENT IDENTIFICATION (RID) NUMBER, & CASE NUMBER, *AND UNDER THE ADDRESSES FIELDS BELOW, PLEASE PRINT THE NAME OF THE HOUSEHOLD MEMBER RECEIVING THE TREATMENT*

FANF Individual

RID #

Case #

FOR DEPT USE ONLY - CHECK IF FOR A HARDSHIP APPLICATION ☐

TO: ☐ **PHYSICIAN or** ☐ **CLINICIAN**

NAME:

ADDRESS:

PHONE:

RETURN TO:

MEDICAL EXEMPTION UNIT (MEU)
DIVISION OF FAMILY ASSISTANCE, DHHS
129 PLEASANT STREET, BROWN BLDG
CONCORD, NH 03301-3857
PHONE: 1-800-852-3345 EXT. 9511
FAX: 271-4637

YOU ARE RECEIVING THIS FORM BECAUSE YOU ARE THE HEALTHCARE PROVIDER FOR:

HOUSEHOLD MEMBER PATIENT'S NAME

Financial Assistance for Needy Families (FANF) program recipients are required to participate in activities that help prepare them for self-sustaining, unsubsidized employment.

The FANF individual named above reports that they have a household member, your patient, that requires them to be in the home to provide care. This care either limits or makes the FANF individual unable to participate in work-related activities. We need your professional assessment to help us determine if this FANF individual has the ability to participate in preparatory and work-related activities.

Your patient should provide you with a signed *Authorization for Release of Protected Health Information* (DFA Form 752A) providing permission for you to release the information in this form to DHHS. Please fax or mail this completed form directly to the Medical Exemption Unit (MEU) using the contact information above. If you have any questions, please call the MEU at the number listed above.

Work-Related and Work Preparation Activities

There are many work-related activities offered to individuals in the work program. FANF individuals can participate in activities that can be adapted to meet the individual's needs and abilities. Activities include:

- **Work-Related Activities -** This may include paid or unpaid work, or structured, supervised work activities that provide the individual the opportunity to experience and acquire the general workplace behaviors, attitudes, skills and knowledge necessary to obtain and retain paid employment.
- **Education or Training -** This may include basic or adult education, ESL or other education or training programs that promote employability.
- **Barrier Resolution** – This may include counseling or other services designed to minimize or resolve a personal issue or other barriers to employment.

Signatures accepted by MD, ARNP, PA, LICSW, LCMHC, and PH.D. Certified nurse-midwife for pregnancy conditions only. All others must obtain corroborative signatures.

Payment of any separate charge for completing this form is the responsibility of the patient. DHHS will not pay charges solely for the completion of medical forms.

NECESSARY PATIENT CARE

(Complete if treating the FANF individual's family member)

Care for: _____

PATIENT'S NAME

_____ _____

FANF Individual's Name **Relationship to Patient**

Diagnosis: _____

Date of onset of condition: _____ **Prognosis (in months):** _____

Comments: _____

	In a 24-hour period, please indicate the level of care needed for your patient's condition:	0 to 1	1 to 3	3 to 6	6 or more
☐	**Daily living skills such as bathing, feeding, dressing, etc.**				
☐	**Administration of medications**				
☐	**Observing/monitoring behavior/medical conditions**				
☐	**Other**				

Indicate the number of medical, school, therapy or other appointments that require a caretaker to accompany your patient. Number of appointments _____ Frequency _____

Indicate other known treatment/service providers: _____

Your patient lives with a FANF individual. The FANF individual has indicated an inability to participate in required work-related activities due to their need to be in the home to care for your patient.

1. Does your patient's condition require someone to be home to care for them? ☐ **Yes** ☐ **No**
2. If YES, does your patient require 24-hour care and/or monitoring? ☐ **Yes** ☐ **No**
3. Is the FANF individual required to be in the home to care for your patient? ☐ **Yes** ☐ **No**

   If NO, please indicate an appropriate person: _____
4. Can the FANF individual participate in work-related activities? ☐ **Yes** ☐ **No**
5. Can the FANF individual participate in work-related activities during school hours? ☐ **Yes** ☐ **No**
6. If YES, indicate the number of hours the FANF individual can participate a week?
   - ☐ 10 – 19 hours
   - ☐ 20 – 25 hours
   - ☐ 26 – 30 hours
   - ☐ 31 – 40 hours
7. If there are restrictions for the FANF individual to participate in work-related activities, how long should these restrictions be in place? (in months) _____
8. If awaiting further results, how long until the evaluation is complete? _____
9. Please indicate any factors that influence the FANF individual's participation: _____
10. List any other recommendations/accommodations for the care of the patient: _____

_____ _____ _____

Physician/Clinician's Signature **Date** **Phone #**

_____ _____

Physician/Clinician's Printed Name **Medical Specialty**